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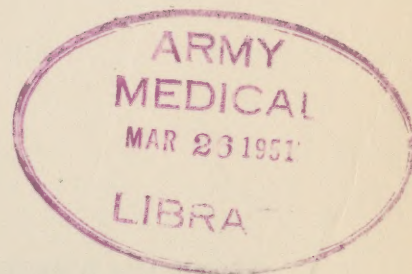
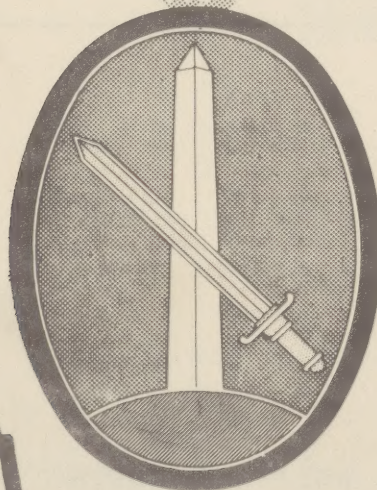
VOLUME 4

REPORT NO. 2

RESTRICTED

# MONTHLY HEALTH REPORT

Military District of Washington



RESTRICTED

February 1951



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HEADQUARTERS, MILITARY DISTRICT OF WASHINGTON  
Room 1543, Building T-7, Gravelly Point  
Washington 25, D. C.



## INTRODUCTION

This publication presents periodic health data concerning personnel of the Department of the Army in the Military District of Washington. It provides factual information for measurement of increase or decrease in the frequency of disease and injury occurring at each of the posts, camps or stations shown herein.

It is published monthly by the Military District of Washington for the purpose of conveying to personnel in the field current information on the health of the various military installations in this area and on matters of administrative and technical interest. Items published herein do not modify or rescind official directives, nor will they be used as a basis for requisitioning supplies or equipment.

Contributions, as well as suggested topics for discussion, are solicited from Army Medical Service personnel in the field.

A handwritten signature in cursive script, reading "Robert E. Bitner", is positioned above the printed name.

ROBERT E. BITNER  
Colonel, MC  
Surgeon

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# PREVENTIVE MEDICINE

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## INTERNATIONAL CERTIFICATE OF INOCULATION AND VACCINATION BY

Brigadier General Wilford F. Hall, USAF (MC)  
Air Surgeon, Military Air Transport Service

Probably all the medical treatment facilities in the geographical limits of the Military District of Washington more or less frequently immunize persons destined for international air travel. Completion of the immunizations is the principal routine medical item of preparation for overseas movement of individuals or units. Many individuals traveling abroad by air require a properly completed International Certification of Inoculation and Vaccination. The international certificate is sanctioned by the various International Sanitary Conventions, and blanks are available through usual publication sources.

Some countries are very strict in examining international immunization records in connection with quarantine clearances at their ports of entry. It has been said that at times some of the quarantine record checks are more bureaucratic than preventive medicine. The records contain several recent instances of detention of persons for minor discrepancies in their records. For example, a party of high ranking staff officers experienced much difficulty in clearing through the civilian quarantine office because the origin and batch number of yellow fever vaccine with which they had been inoculated did not appear on some of their records. Some of the members of the party had been inoculated against yellow fever by medical installations in the Washington area.

MATS ports of aerial embarkation and certain en route stations check immunization records prior to accepting the individuals for air transportation. This MATS check is useful, but we can not expect it to keep every individual out of trouble with foreign quarantine authorities. Many individuals travel by other means than MATS aircraft, for example. Moreover, our stations report they are having difficulties in supplying travelers with international certificates because the information necessary to complete them is not available on the records furnished by Armed Services medical facilities. Comparison of the military type record and the international certificate will show that this is quite true. Chief reliance must, therefore, be placed on proper completion of the international immunization records at the point where the immunizations are administered. POR and POM require that immunization records be properly completed at the home station, prior to arrival at the port.

Some of the discrepancies on international records which have been noted and which may well embarrass the individual are:

Origin and batch number of vaccine not recorded.

Autograph signature (not initials) of certifying physician and inoculating physician not affixed.

Signatures by nurses or personnel other than physicians.

Inoculating and certifying physicians only initial the record instead of signing it in full.

Rubber stamps are used instead of affixing autograph signatures.

Results of smallpox vaccination not properly recorded.

Signatures of the traveler not affixed in the spaces provided.

Failure to complete pertinent blank spaces on the form.

The traveler does not know which immunizations or records are required for his trip. He depends largely on the good judgment of the medical facility to which he reports for immunization. Both the traveler and MATS will appreciate the efforts of all concerned to complete every pertinent blank space in accordance with the instructions printed on the form. If the instructions are closely adhered to, the traveler can confidently expect his record to be acceptable for most any area.

Illustration for International Certificate is reproduced on page 2.



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# ADMINISTRATIVE SERVICE

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## DIETITIAN AS MESS ADMINISTRATOR

By

Captain Josephine C. Lydon, WMSC  
U. S. Army Hospital, Fort Belvoir, Virginia

In keeping with the current trend in specialization that has been introduced in the administrative as well as the professional staff of the U. S. Army Medical Service, and in step with the progress that has been made in the field of dietetics and food service, the Surgeon General has authorized hospital commanders to appoint a member of the Women's Medical Corps as Hospital Mess Administrator.

This is a role for the dietitian to assume, for it broadens the scope of her responsibilities from that of technical supervisor to that of director of the entire mess activity. It places the authority for functional control of the hospital mess and the responsibility for maintenance of nutritional balance, under one supervision.

In August of 1950, in addition to my duties as Chief Dietitian, I was appointed Hospital Mess Administrator of the U. S. Army Hospital, Fort Belvoir. My responsibilities and duties as mess administrator include the following:

The direction and supervision of the procurement of food, preparation and planning of menus, and the operation of messing facilities within the hospital. The planning of menus within ration allowances; training personnel in proper care, storage, conservation, preparation, and serving of food, and to promote efficient mess management.

Conduct inspections of messes to insure compliance with existing regulations regarding distribution, preparations, consumption, and conservation of food; supervise maintenance and care of messing equipment and the keeping of accounts and preparation of reports.

My responsibilities and duties as the hospital dietitian include the following:

Supervise the preparation of food for patients of the U. S. Army Hospital, Fort Belvoir. Construct standardized recipes and direct the preparations and serving of food with emphasis on nutrients, palatability, and attractiveness; calculate and direct the preparation and service of special and metabolic diets prescribed by medical officers; instruct patients in correct food and dietary habits; plan daily menus with special reference to proper diet and nutritional balance so as to utilize available food supplies.

### Additional Duties:

Direct the training and supervision of other dietitians assigned to the U. S. Army Hospital, Fort Belvoir. Perform additional administrative and dietary functions as prescribed by the commanding officer of the hospital. I act as member of menu board for post (Fort Belvoir), and assist in the preparation of menus for nutritional adequacy, dietary balance, and procurement practicability and make recommendations for change in quantities and for improvements in the master menu.

In addition to my duties as hospital dietitian and mess administrator I have been for the past few months engaged in a research project under the direction of the Office of the Quartermaster General, pertaining to the caloric requirements for WAC personnel. A group of WAC's stationed at Fort Belvoir have been undergoing a controlled diet to establish the nutrient requirements necessary for them to carry on their ordinary daily activities.

### EDITOR'S NOTE:

When Captain Lydon assumed responsibility for the Hospital Fund at U. S. Army Hospital, Fort Belvoir, the fund had been losing money for the four (4) previous months. Since then she has been able to place the fund on a profitable basis, paying off an old loan and during the month of September 1950 effected a savings per ration of 26 cents. Captain Lydon is to be congratulated for her fine work at U. S. Army Hospital, Fort Belvoir.

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# ADMINISTRATIVE SERVICE

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## MILITARY PERSONNEL

### Utilization of Certain Medical Service Corps Officers.

1. Information reaching Hq, DA, indicates insufficient delegation to and assumption by Medical Service Corps officers engaged in hospital administration of certain administrative duties. This is not in the common interest.

2. Pending publication of a DA regulation covering the general mission of the Medical Service Corps, the following may be referred to:

"The Medical Service Corps consists of officers some of whom are skilled in sciences allied to medicine and others who are skilled in special management techniques peculiar and necessary to the function of each of the medical and allied professions required for an efficient medical service. Under the command of an appropriate Medical Corps officer, those officers skilled in management techniques organize and operate an efficient medical economy so that professional categories of Medical Department personnel, relieved to the maximum extent practicable of nonprofessional military and administrative responsibilities, may perform duties of maximum value to the service and to themselves."

3. The availability of Medical Department professional personnel makes mandatory maximum efficiency in their utilization. Administrative and other nonprofessional duties that can or should be assumed by MSC officers must not be delegated to professional personnel. Medical Department professional personnel should be freed to the maximum extent possible for the performance of duties requiring professional medical training and experience.

4. It is impracticable to classify to the utmost detail each function of each component of the Medical Department, and to indicate what duties should be accomplished by each. In general, professional duties will be performed by personnel who have had professional training and experience, and administrative duties requiring not professional but administrative training and experience, by appropriate MSC officers. Normally except for the inescapable necessity of MC officers exercising command of medical installations where patients are treated, and overall direction of Medical Department activities, the above general demarcation should be rigidly adhered to. Cited are a few examples which indicate the general delineation of functions between MC and MSC officers at army hospitals.

#### a. Assignments.

(1) Medical Corps: Commanding Officer, Deputy Commanding Officer, Assistant Commanding Officer, Ward Officer, Training officer (limited to professional assignments, such as at general "teaching" hospitals), Instructor.

(2) Medical Service Corps: Executive Officer, Commanding Officer Medical Detachment Enlisted Men, Commanding Officer Detachment of Patients, Supply Officer, Personnel Officer, Ward Administrative Officer, Medical Registrar, Hospital Inspector, Training Officer, Instructor.

#### b. Duties.

(1) Duties of chiefs of professional services, ward officers and other MC officers primarily dealing with the treatment of patients involve the handling of certain necessary professional administration, such as clinical histories and allied correspondence. Functions of ward administrative officers and other MSC officers assigned to the various hospital professional services include all duties of a purely administrative nature which can be delegated by MC officers.

(2) Functions of hospital inspectors are normally confined to inspection of conditions of discipline, training, and morale; physical facilities and equipment; administrative activities; and special inspections of audits of funds and property.

(3) MSC officers normally assume all property accountability and formal property responsibility. MC officers' functions with respect to supply are confined to general

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## ADMINISTRATIVE SERVICE

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supervision and direction. Normally they assume formal property responsibility only when MSC officers are unavailable.

(4) MSC officers are normally responsible for formulating, coordinating and operating training programs and schedules except that all phases of professional training for MC officers, such as those at general "teaching" hospitals, are assumed by MC officers.

(5) Formal instruction by MC officers is limited to professional and professional technical subjects. Formal instruction by MCS officers consists of administrative and military subjects, including all others not requiring professional knowledge.

(6) MC officers will not serve as members of boards which do not require professional medical opinion except where exigencies require their appointment to court martial boards. They will not perform duties of a precautionary nature, such as attendance at firing ranges and athletic events, when qualified MSC officers or enlisted technicians are available. MSC officers will be substituted for professional personnel in performance of all additional duties that do not require the knowledge or immediate presence of MC officers.

5. Immediate steps will be taken to survey and insure proper delineation of functions between professional categories of Medical Department personnel and appropriate MSC officers.

(The above article is from SGO Circular 113, 12 September 1949, Section V.)

### PREPARATION OF INDIVIDUAL MEDICAL RECORDS REPORTING INJURY

If the diagnosis indicated is due to an injury the specific nature of which should be stated. Whenever a patient is admitted for treatment of a residual condition which is the result of a former disease or injury, the residual condition should be shown as the cause of admission. It will be followed by a statement specifying the nature of the former disease or injury and the date of its occurrence (par 3, TB MED 203). If "old," the diagnosis should be reported in accordance with paragraph 11b(2), TB MED 203.

Qualifying information concerning the incurrence of the injury recorded as the diagnosis should be submitted. Complete recording of the injury will specify the nature of the injury; its causative agent; part or parts of body affected; circumstances under which the injury occurred; activity in which the person was engaged at the time of the injury and place and date of injury (par 22b(2), TB MED 203, and Sec 1, par 5a, SR 40-1025-1, 1 April 1949).

If the diagnosis has been qualified as "old" it should indicate that either the current condition or the injury has been previously treated by an Army medical installation. The "old" diagnosis is recorded in compliance with paragraph 11, TB MED 203.

The term "injury" or "trauma" is not acceptable as a diagnosis. The exact nature of the injury should be stated (as outlined in par 22b(2), TB MED 203).

(Reports Control Symbol 19, Medical Report Card WD AGO Form No. 8-24, 1 July 1944)

### UTILIZATION OF ENLISTED PERSONNEL PARTIALLY DISABLED BY COMBAT WOUNDS

In Special Regulation 615-220-41, dated 4 December 1950, it is prescribed that the administrative procedures and criteria under which enlisted personnel of the Army who are partially disabled by combat wounds may be retained on active duty if they so desire. It will be noted that the individual must be partially disabled as a result of wounds incurred in combat operations, other than those resulting in intentional misconduct, willful neglect, or those incurred during a period of unauthorized absence. The utilization of enlisted personnel partially disabled by combat wounds would be restricted in assignment to overhead installations, such as depots, ports of embarkation, administrative headquarters, training installations, and repair facilities.

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# ADMINISTRATIVE SERVICE

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## IMPORTANCE OF MEDICAL RECORDS AND REPORTS

The mission of the Medical Service is to conserve the fighting strength of the military forces. This is accomplished by: (1) selection for military service, through properly conducted physical examinations, of only those men and women who meet the approved standards of fitness to perform duty; (2) preservation of the health and physical well-being of military personnel through the application of modern principles and concepts of preventive medicine; (3) furnishing those who become disabled with such aid, in the form of evacuation and hospitalization facilities, as will speedily restore them to health and fighting efficiency.

In accomplishing this mission the Medical Service performs many functions, one of which is the maintenance of proper records and reports. The records and reports of sick and wounded are designed to furnish complete personal and diagnostic information on each individual patient, including personnel killed in action, as well as to provide general account of outpatient service. Such records and reports are necessary in order that:

1. Data may be available for the conduct of business of the Department of the Army and other governmental agencies, with particular reference to retention of the physically fit in the service, assignment to duty, adjustment of pay accounts, and adjudication of claims for compensation or pension. Thus we see they are important to the individual officer and soldier, for these records may effect his pay, payments to his beneficiary, or his claim against the government for disability allowance.

2. Detailed scientific studies may be made on the incidence, nature and aftereffects of diseases, injuries and wounds.

3. The adequacy and effectiveness of the diagnostic and therapeutic measures of the Army may be properly evaluated. On the basis of medical records the Medical Service determines the value of certain procedures.

4. The Medical Service may have basis to estimate requirements for future operations and to plan operations.

5. Data may be obtained upon which to base plans for medical service for the personnel of the Army as well as those separated from the Army because of medical reasons.

In view of the wide utilization of the data on sick and wounded reports, it is essential that the required facts be stated completely and concisely. The commanding officer of each medical installation is responsible for the reports and their forwarding when due.

It is important that each Medical Service Officer be familiar with the procedures and principles for maintaining these records, not only for the protection of the individual, but also to accomplish successfully this function of the Medical Service.

(The above article is from Extension Course of the Medical Field Service School, Subcourse 30-3)

## COMPLETE TEXT OF VA RELEASE ON REHABILITATION OF KOREAN WOUNDED

The President has signed a law extending Public Law 16 rehabilitation training to many veterans disabled since fighting started in Korea.

Under the new law, veterans disabled while on active duty on or after June 27, 1950, may be entitled to Public Law 16 education and training if they meet the following three requirements:

1. They must have been separated from service under conditions other than dishonorable.

2. They must be in need of training to overcome the handicap of a disability incurred in or aggravated by military service on or after June 27, 1950; and,

3. The disability must have resulted from conditions under which the Veterans Administration pays compensation at full wartime rates.

(The above article is from "Service Stripe", WRAH, AMC, Washington, D. C., Vol 7, No. 4)

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# STATEMENT OF LT. GENERAL RIDGWAY

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## STATEMENT BY LT GENERAL MATTHEW B. RIDGWAY COMMANDING GENERAL, 8th ARMY

In my brief period of Command duty here I have heard from several sources, chiefly from the members of combat units, the questions, "Why are we here?" "What are we fighting for?"

What follows represents my answers to those questions.

The answer to the first question, "Why are we here?" is simple and conclusive. We are here because of the decisions of the properly constituted authorities of our respective governments. As the Commander-In-Chief, United Nations Command, General of the Army Douglas MacArthur said publicly yesterday:

"This command intends to maintain a military position in Korea just as long as the statesmen of the United Nations decide we should do so."

The answer is simple because further comment is unnecessary. It is conclusive because the loyalty we give, and expect, precludes any slightest questioning of those orders.

The second question is of much greater significance, and every member of this command is entitled to a full and reasoned answer. Mine follows:

To me the issues are clear. It is not a question of this or that Korean town or village. Real estate is, here, incidental. It is not restricted to the issue of freedom for our South Korean Allies, whose fidelity and valor under the severest stresses of battle we recognize; though that freedom is a symbol of the wider issues, and included among them.

The real issues are whether or not the power of Western civilization, as God has permitted it to flower in our own beloved lands, shall defy and defeat communism; whether the rule of men who shoot their prisoners, enslave their citizens, and deride the dignity of man shall displace the rule of those to whom the individual and his individual right are sacred; whether we are to survive with God's hand to guide and lead us, or to perish in the dead existence of a Godless world.

If these be true, and to me they are, beyond any possibility of challenge, then this has long since ceased to be a fight for freedom for our Korean Allies alone, and for their national survival. It has become, and it continues to be, a fight for our own freedom, for our own survival, in an honorable, independent national existence.

The sacrifices we have made, and those we shall yet support, are not offered vicariously for others, but in our own direct defense, wherein certain principles mean more than life.

In the final analysis, the issue now joined right here in Korea is whether Communism or individual freedom shall prevail, and, make no mistake, whether the next flight of fear-driven people we have just witnessed across the Han River, and continue to witness in other areas, shall be checked and defeated overseas or permitted, step by step, to close in on our own home lands and at some future time, however distant, to engulf our own loved ones in all its misery and despair.

These are the things for which we fight. Never have members of any military command had a greater challenge than we, or a finer opportunity to show ourselves and our people at their best--and thus be an honor to the profession of arms, and a credit to those who bred us.

I would like each Commander to whom this is addressed, in his own chosen ways of leadership, to convey the substance of this message to every single member of his Command. and at the earliest practicable moment.

(The above was broadcast on the Department of Defense radio program, "Time for Defense," on 25 January 1951).

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## NURSING SERVICE

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### HAVING A BABY IS A FAMILY MATTER

BY

Faith E. Jensen

One evening last January, while I was still assigned to the obstetric service, I was telling my grandmother about some of the "new" technics being employed at the hospital. I explained that now a great number of women were fully conscious all the while their babies were being born, and that the infants were very often kept in cribs beside each mother's bed. When I'd finished my recital, she patted on arm indulgently and said, "My dear, what you've told me is really not so 'new', for most of the women in my generation had their children that way, only they had them at home."

The large, impersonal maternity wards and nurseries have been an out-growth of this shift in obstetric care from home to hospital, and psychologically the family unit - mother, father and baby - have sometimes suffered. I was glad that here in New Haven Hospital I could have a part in a program that advocates natural childbirth and thereby gives each mother an opportunity to have a safe and satisfying delivery and that simulates the naturalness of home in the hospital by placing the mother and baby in the same room.

What is natural childbirth? Like the child who was asked to define a rooster and said, "A rooster is what a chicken ain't," I will say at the outset that natural childbirth, as we understand it, is not divorced from analgesia, anaesthesia, and obstetric management. Any one of these may be necessary to make the experience safe and satisfying for the mother, but more frequently than not they are unnecessary, for in eliminating a woman's fears we may alleviate the sequelae of tension and pain.

The prospective mother is prepared to understand childbirth long before delivery. She attends the antepartal clinic during the entire course of her pregnancy, but comes more frequently during the seventh, eighth, and ninth months. The doctor examines her at every visit, and checks her kidney function, blood pressure, weight and diet, as well as an oft neglected aspect, her mental well-being. She attends a series of doctor's lectures which tell her about her own anatomy and physiology, how she can recognize the sign of beginning labor, what the three stages of labor are, and then the principles of natural childbirth. She attends exercise classes which are conducted by nurses who were specially prepared for this teaching. There she is taught how and when to relax, and how to do exercises which will strengthen her pelvic and abdominal muscles for their big task of helping to push the baby through the birth canal. Nursing students attend these same classes, and practice the exercises that are taught to the prospective mothers. The patient is taken on a tour of the labor and delivery rooms a week or so prior to her expected date of confinement in an attempt to make her labor and delivery and experience of known values rather than unknowns and fears.

The pediatrician who supervises the infants in the rooming-in project sees the prospective parents during this antepartal period. He generally introduces himself as "the baby doctor" and, in addition to determining their eligibility for rooming-in, endeavors to find out how "wanted" this baby is going to be. If he detects gross fears and social problems, he refers the patient to a psychiatrist or social worker at a time when positive action can be taken.

Now, let us assume that the mother has conscientiously attended the clinic during her pregnancy. She is admitted to the ward, in labor, and a student nurse is assigned to be with her during her labor and delivery. The nurse's function is that of a sympathetic and understanding friend. She learns that this will be the first baby in the family and she notices how elated the mother and father are. The routine procedures - perineal preparation, enema, and vitamin K therapy - are taken care of first. The mother has been previously prepared for these procedures. She expresses a desire to see her husband and he is allowed to be with her during the course of her labor. He is actively interested in her progress and may even wish to hear the fetal heart himself. He steps out periodically when the doctor does the rectal examinations, and the patient asks eagerly, "How'm I doing, Doc?" When her smile becomes forced the nurse encourages her along with relaxation exercises and she rubs her back to relieve the nagging backache. She must read the mother's moods and talk with her when she needs support, and be silent when she doesn't want to talk. But, most important of all, the nurse is seated there at her bedside and the woman has someone to identify with during the long hours of labor.

When her cervix is fully dilated she suddenly comes to life again, grows excited, and wants

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## NURSING SERVICE

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to "push." She's wheeled to the delivery room and with a few good contractions has produced her first baby. "A boy!" Her face is transfigured at this moment and she eagerly welcomes her new baby into her arms. This is the pattern I've seen over and over in so many of the mothers who have prepared for natural childbirth. They regard the whole process as an exciting and marvelous experience.

The nurse tidies up the delivery room while she keeps a weather eye out for the mother who is crooning to her baby son. Then she pushes the bed out into the hall and the husband, who's been waiting there impatiently for the last hour, helps push his "family" back to the ward room or to the rooming-in section, if they've elected that plan of care. There the couple are left alone for a few moments to get acquainted with their offspring and to congratulate each other. The baby is then removed to the central nursery or to the rooming-in nursery so that the mother can rest during the next twenty-four hours. In the rooming-in plan the mother will then gradually take over the baby's care.

Rooming-in, as we know it, is the arrangement whereby a mother may have her newborn baby in a crib by her bedside whenever she wishes. It is not the physical set-up, however, that makes the rooming-in project so successful, but it is the spirit of co-operation that exists between everyone concerned - the pediatricians, obstetricians, nurses, and the families. It's a spirit you catch the moment you cross the threshold.

I look back on my experience in rooming-in as the highlight of my student days! First, because of the relationships I enjoyed there. When one sees the mother and baby together there's a completeness to the picture that's as striking as a jigsaw puzzle to which you've just added the key piece. I recall one young woman who, propped on her elbow, was gazing devotedly at her day-old son. I'm sure that if she had voiced her thoughts at that moment she'd have said, "We've been inseparable for nine months, it's only right that he should be here with me now." In contrast, when I've worked in the floor nursery, it has often been my painful privilege to call for the babies after they've spent a brief half-hour with their mothers, and I'll never forget one mother handing her little pink bundle to me with a sigh and saying, "I'll have to wait to get acquainted with her at home." In essence she was paraphrasing the words of one child psychologist who said that the soma is born in the delivery room, the psyche at home.

One also sees the father-child relationship - an unheard of thing in the ward. I've often wondered how much identification there can be between father and son when a pane of glass separates them? The fathers of babies who "room in" are a very enthusiastic lot. On the stroke of the visiting hour, they come striding down the hall, greet their wives warmly, and begin to wash their hands with an amazing thoroughness. They slip into gowns, and sit down on the edge of their chairs just dying to have friend son or daughter wake up so that he or she can be held. There's decided rivalry between these daddies, to see who's most accomplished in the "manly art" of feeding and diapering a baby. One timid soul got a verbal "Silver Star" from his friend in the unit when he picked up his baby for the first time.

Another gratifying aspect of rooming-in is the personal relationships we enjoy. If a mother seems uncertain about how to bubble her baby, and the nurse is occupied elsewhere, the doctor gladly demonstrates for all concerned. True, the doctor has his work to do, the nurse hers, but there's a flexibility to the division of labor that one isn't apt to find elsewhere. It's a family relationship where every person is concerned with the other person's problems.

The second big advantage of rooming-in to me, was the ideal teaching, learning opportunities I had. With the baby right there beside her, the mother could ask questions as they occurred to her: "Why are his stools that color? Why does he make such strange noises when he sleeps? Why did his cord turn black?" These and similar questions helped prepare the mother to care for her baby at home. If we students didn't know all the answers, and believe me we didn't, we could always consult the graduate nurses and doctors. A wealth of reference material was also available in the unit for our information and for the parents. We kept a list of questions that the mothers asked us and so, in time, we were prepared to anticipate many of the problems. On the pediatric service, we had learned a great deal, theoretically speaking, about normal newborn babies, but we had seen only a few newborns and most of these were premature babies that had been transferred from the obstetrics nursery. This was the golden opportunity to put our theory into practice, and we learned very soon how much of an individual each baby was.

Third, we had an opportunity to give ideal nursing care. Activities in the rooming-in pro-

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## NURSING SERVICE

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gram moved at a different pace from those on the rest of the obstetrics service. Except for serving meals, taking temperatures, and admitting visitors at specific times, we could gear our nursing care to the mother's convenience. If she had been up a good part of the night nursing the baby, and wished to sleep in the morning, she could have her bed bath in the afternoon. To keep the number of people who entered the unit at a minimum, we did the housekeeping that usually fell to the porter or a maid to do. We were kept very busy but we did not feel pressed for time. We all took a homey sort of pride in rooming-in with its gay chintz curtains, rocking chairs, and flowers. The mothers were considerate of one another and of us, their nurses. If the nurse was busy in one corner of the room and a baby started to fuss, the mother would try to comfort him until the nurse could lend her a helping hand. A mother who had had two or three children was often already an authority on "bringing up the baby," and often these mothers helped with part of the teaching.

Over a year has passed now since I had my obstetrics and rooming-in experience. Since then I've had two additional affiliations which have served to point out to me the rewards of this rich experience. In psychiatry we learned that the seeds of mental illness are often sown in infancy and early childhood. Fortunate is the baby who has 24-hour acceptance of security from the hour he is born. Fortunate is the mother who learns to know and handle her baby in an atmosphere of reinforcement, and fortunate is the father who can play a leading role in this drama of family life and not be just one of the supporting cast during the first five days of his baby's life. Rooming-in is not a cure-all for mental illness, but it is certainly a step in the right direction toward establishing good family relationships.

Most of the nursing students here at Yale believe in natural childbirth and rooming-in and we say "that's the way we'd like to have our babies."

(The above article is from American Journal of Nursing, Vol 50, No. 10, Pages 674 to 675, October 50)

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## VETERINARY SERVICE

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### SOME PROBABLE CAUSES OF SHORTAGES IN WEIGHT IN FROZEN MILK CONTRACTS

Observation has indicated that homogenized milk tends to foam more readily than plain milk. In order to prevent this excessive foaming a local approved dairy runs their milk from the cooler pan into a 3000 gallon tank trying to maintain a milk level of at least 1500 gallons in the tank while bottling. They have found that bottling direct from the cooler pan results in excessive foaming and thus incomplete filling of the carton or bottle. Temperature of milk during bottling also has an influence on the amount of foam. We have found that by bottling the milk at 38° F. there is very little foaming. Another factor to consider is the speed of the bottling machines. It has been observed that some machines operating at full capacity tend to set up excessive foaming and, therefore, weight shortages.

### MILK CONCENTRATE, FRESH AND FROZEN

This newly developed fresh fluid concentrate is being processed by several companies. Those who have tried the product generally agree that there is no difference in taste, color or body from regular milk.

Some research individuals who have worked on this process for several years are of the opinion that they have reached the stage in their investigation whereby they can start with fresh local milk of Federal Specification C-M-381e, No. 2 grade and their end product (the reconstituted product) will have the identical flavor characteristics, etc. They do not claim to be able to take a poor quality milk and improve it. Therefore, it should be understood from the beginning that here, again to obtain a top quality product only the low bacteria count best quality milk is acceptable for the concentrate.

Details as to processing methods by which the fresh flavor is retained despite heating during processing is guarded at present. The milk is heated and placed in a vacuum pan and the know how applied here. It is homogenized and Vitamin D fortified. It should be pointed out that no chemicals are added and nothing removed but two-thirds of the water content. Some concerns are re-

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## VETERINARY SERVICE

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moving as much as three-fourths of the water. On reconstitution the ratio will, of course, be determined by the amount of water removed.

One of the outstanding features of this product is the fact that the fresh fluid concentrate kept at a temperature of 40° F. will keep two weeks without souring, flocculation or curdling. When the product is reconstituted the keeping qualities will be about the same as ordinary fresh milk. If the concentrate is frozen the keeping qualities will be from three to four months.

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## ADMINISTRATIVE SERVICE

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### MILITARY PERSONNEL

#### Career Management of Medical Corps Officers.

Within the scope of military medicine army medical officer professional assignments range from routine sick call and physical examinations to the highest degrees of professional attainments.

It is axiomatic that such progression gears itself, fittingly, to age, experience, training and ability. It is traditional in military, as well as in civilian medicine, that the less interesting occupations are awarded to the newly commissioned officers or young doctors. Young doctors entering the service are not shocked by this system and recognize it as necessary foundation to their careers. Since there are many other initial professional occupations of less routine character than physical examinations or dispensary duty, it is important to the morale assignment to be periodically made.

It is therefore incumbent upon commanding officers of medical installations to immediately effect a system of local rotation which will prevent any Medical Officer from being assigned to any of the recognized monotonous professional duties for periods longer than 6 months at a time, unless conditions beyond their control prevent it. Obviously, this policy is not intended to interfere with any professional training program, nor should it materially create interference with such domestic necessities as housing, children's schools, etc. The subject concerns itself principally with morale and, as such, remains one of local determination that cannot relegate itself to rigid policy.

Junior Medical Officers assigned to Field Organizations and Tactical Units, and those who have chosen Tactical careers, will be required to intersperse tours of professional assignments between tours of Field Unit assignments.

(The above article is from SGO Circular 172, Section III, dated 27 December 1950).

### X-RAY FILM (IX-513)

Medical Supply Information Letter No. 143, Schenectady General Depot, U. S. Army, Schenectady, New York, is reproduced below:

1. Advice is furnished that due to procurement difficulties which have arisen, x-ray film has become an item of critical supply. During this critical period and until further advised, Medical Supply Officers at Army stations and Air Force Bases are requested to take the following action:

- a. Insure that every effort is made to observe strict supply discipline and to requisition only minimum requirements.
- b. Effect local procurement of required x-ray film when depot stocks are not available.

2. With reference to paragraph 1b preceding, it is advised that stations will not procure x-ray film without first obtaining approval for purchase and the citation of necessary funds from this depot. Depending upon the urgency of the requirement approval for purchase may be made by telephone, teletype and/or mailed requisitions. The only exception to the foregoing is an emergency purchase under the provisions of AR 40-1705.

3. In the event arrangements can be made between supply officers to utilize stocks not essentially required by one installation, but in short supply at another activity, lateral distribution may be effected without reference to this office.

# ADMINISTRATIVE SERVICE

## MEDICAL STATISTICAL REPORTS

Below is a suggested guide for computing the rate per 1,000 troops per annum (required for Medical Statistical Reports), that has been found by experience to result in a savings of time required to produce accurate Medical Service statistics for certain reports.

It is believed that the use of this guide will be of particular value to those medical facilities within the Military District of Washington that are not equipped with a comptometer. The basic calculations have been reduced to chart form. All that is necessary is to look up the number of cases in the proper time factor chart for seven (7) days, twenty-eight (28) days, or thirty-five (35) days (whichever is applicable), and then divide the figure opposite the number of cases by the average strength for the corresponding period of time in order to obtain the rate per 1,000 per annum on that particular interval of time that the statistics cover.

### GUIDE FOR COMPUTING THE RATE PER 1,000 TROOPS PER ANNUM

No. Cases	1 Week Period	4 Week Period	5 Week Period	No. Cases	1 Week Period	4 Week Period	5 Week Period	No. Cases	1 Week Period	4 Week Period	5 Week Period
1	52,143	13,035	10,428	26	1,355,718	338,910	271,128	51	2,659,293	664,785	531,828
2	104,286	26,070	20,856	27	1,407,861	351,945	281,556	52	2,711,436	677,820	542,256
3	156,429	39,105	31,284	28	1,460,004	364,980	291,984	53	2,763,579	690,855	552,684
4	208,572	52,140	41,712	29	1,512,147	378,015	302,412	54	2,815,722	703,890	563,112
5	260,715	65,175	52,140	30	1,564,290	391,050	312,840	55	2,867,865	716,925	573,540
6	312,858	78,210	62,568	31	1,616,433	404,085	323,268	56	2,920,008	729,960	583,968
7	365,001	91,245	72,996	32	1,668,576	417,120	333,696	57	2,972,151	742,995	594,396
8	417,144	104,280	83,424	33	1,720,719	430,155	344,124	58	3,024,294	756,030	604,824
9	469,287	117,315	93,852	34	1,772,862	443,190	354,552	59	3,076,437	769,065	615,252
10	521,430	130,350	104,280	35	1,825,005	456,225	364,980	60	3,128,580	782,100	625,680
11	573,573	143,385	114,708	36	1,877,148	469,260	375,408	61	3,180,723	795,135	636,108
12	625,716	156,420	125,136	37	1,929,291	482,295	385,836	62	3,232,866	808,170	646,536
13	677,859	169,455	135,564	38	1,981,434	495,330	396,264	63	3,285,009	821,205	656,964
14	730,002	182,490	145,992	39	2,033,577	508,365	406,692	64	3,337,152	834,240	667,392
15	782,145	195,525	156,420	40	2,085,720	521,400	417,120	65	3,389,295	847,275	677,820
16	834,288	208,560	166,848	41	2,137,863	534,435	427,548	66	3,441,438	860,310	688,248
17	886,431	221,595	177,276	42	2,190,006	547,470	437,976	67	3,493,581	873,345	698,676
18	938,574	234,630	187,704	43	2,242,149	560,505	448,404	68	3,545,724	886,380	709,104
19	990,717	247,665	198,132	44	2,294,292	573,540	458,832	69	3,597,867	899,415	719,532
20	1,042,860	260,700	208,560	45	2,346,435	586,575	469,260	70	3,650,010	912,450	729,960
21	1,095,003	273,735	218,988	46	2,398,578	599,610	479,688	71	3,702,153	925,485	740,388
22	1,147,146	286,770	229,416	47	2,450,721	612,645	490,116	72	3,754,296	938,520	750,816
23	1,199,289	299,805	239,844	48	2,502,864	625,680	500,544	73	3,806,439	951,555	761,244
24	1,251,432	312,840	250,272	49	2,555,007	638,715	510,972	74	3,858,582	964,590	771,672
25	1,303,575	325,875	260,700	50	2,607,150	651,750	521,400	75	3,910,725	977,625	782,100

# PREVENTIVE MEDICINE

RESTRICTED

## GENERAL DATA

The health of the command continued to be excellent.

Unless otherwise indicated, reference to disease and injuries in this publication applies to all Class I and Class II installations exclusive of Walter Reed Army Hospital. Rates are calculated on the basis of a thousand mean strength per year. Statistics presently reported by Army Medical Service installations do not include Air Force personnel. (See General Data and Admission Tables on page 14).

The non-effective rate\* decreased from the December rate of 16.69 to 15.50 for the month of January. Days lost as a result of disease and injury totaled 11,299 during the four week period ending 26 January 1951.

$$\text{*Non-Effective Rate} = \frac{\text{Total Days lost} \times 1,000}{\text{No. of Days in Period} \times \text{Average Daily Strength}}$$

Non-effective rates indicate the average number of patients in hospital or quarters per thousand mean strength during the report period.

The total admission rate\*\* for disease and injury in January was 588.9, compared to 675.1 during December. Total admission for disease and injury in January was 1176. Of this number, 1048 admissions were for disease and 128 injuries. Fort Myer reported the highest admission rate, and All Others reported the lowest rate during the current month.

$$\text{**Admission Rates} = \frac{1,000 \times 365 \times \text{Number of Cases}}{\text{Mean Strength} \times \text{No. of Days in Period}}$$

Admission rates show the number of cases per thousand strength that would occur during a year if cases occurred throughout the year at the same rate as in the report period.

January's rate for disease cases is 524.8 for 1048 cases. Fort Myer reported the highest admission rate, and All Others reported the lowest rate for disease cases.

An injury admission rate of 64.1 per 1,000 per annum for January was reported. This was an increase from the December rate of 75.8. Fort McNair reported the highest rate and All Others reported the lowest rate for injuries.

There was 4 deaths reported during the four-week period ending 26 January 1951, by units within the Military District of Washington less Walter Reed Army Hospital.

## COMMUNICABLE DISEASE

Common respiratory diseases decreased in incidence during the month of January 1951. The rate for the present month is 225.8, compared to the December rate of 253.2. Fort Myer reported the highest rate, and Fort McNair, reported the lowest rate. Admission rates for pneumonia (all types) decreased during the December report period. The rate being 8.5 compared with the December rate of 13.9. There were no cases of scarlet fever reported throughout the month of January.

No appreciable change was noted in the rate for mumps, tuberculosis, rheumatic fever, diarrheal disease, and hepatitis during the four week period ending 26 January 1951.

Pertinent statistical tables may be found on pages 15 and 19.

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## PREVENTIVE MEDICINE

GENERAL DATA  
4-Week Period Ending 26 January 1951  
(Data from WD AGO Forms 8-122)

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ADMISSIONS, SPECIFIED DISEASES - RATE PER 1000 PER YEAR  
4-Week Period Ending 26 January 1951  
(Data from WD AGO Forms 8-122)

STATION	Common Respiratory Disease	Pneumonia All Types	Pneumonia Atypical	Measles	Mumps	Scarlet Fever	Tuberculosis	Rheumatic Fever	Diar-rheal Disease	Hepatitis	Malaria	Influenza	Psychiatric Disease
Fort Belvoir, Virginia	103.50	11.59	4.97	17.39	7.45	-	2.48	2.48	-	.83	-	24.97	5.80
Fort McNair, Wash., D.C.	65.26	-	-	-	-	-	-	-	-	-	-	-	-
Fort Myer, Virginia	470.16	6.31	-	-	-	-	-	-	12.62	-	-	25.24	-
US Army Dispensary, The Pentagon	169.47	3.53	3.53	-	-	-	-	-	-	-	-	-	-
All Others	-	-	-	-	-	-	-	-	-	-	-	-	-
Total - Military District of Washington	225.86	8.51	8.51	10.52	4.51	-	1.50	1.50	2.01	.50	-	9.52	3.51
AMC - Med Det (Duty Pers)	34.80	17.40	-	17.40	-	-	-	-	-	-	-	-	-

## MANAGEMENT REFERENCE LIBRARY

Action has been taken to provide an initial issue of management reference books for each Class II hospital, and each Continental Army Surgeon's Office.

These reference books are provided as aids to be used in the development of the management improvement program sponsored by the Surgeon General. Since it is not possible to supplement the present skills of all officers engaged in hospital management and administration, these books will permit these officers to add to their education and further their development in these fields. These officers should be encouraged to study these books in order that they may keep abreast of the field in the knowledge and application of accepted principles and techniques of scientific management.

It is suggested that the formation of study or discussion groups at hospitals, using these reference books as texts, would assure maximum benefit to the largest number of officers. In conjunction with study or discussion, local business executives are usually happy to participate in programs of this sort. This plan has been tried successfully in some Army hospitals.

(The above article is from SGO Circular 172, Section III, dated 27 December 1950)

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# PREVENTIVE MEDICINE

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## VENEREAL DISEASE

Venereal Disease rate among units within the Military District of Washington, increased during the January report period.

The rate for January 1951, was 13.52 increasing over the December rate of 12.71. A total of 27 cases were reported for the four week period ending 26 January 1951. Of this total 25 were reported by Fort Belvoir, 1 for Fort Myer, and 1 for All Others.

During the report period, white personnel incurred 14 of the reported number of cases, with a rate of 7.56 and 13 were incurred by negro personnel, with a resulting rate of 89.85 per 1000 troops per annum.

In order to enable non-professional personnel to more intelligently understand the rates of cases to personnel on duty at each designated station, we have undertaken to report the number of cases per 1000 men for this report period (January) in addition to the rate per 1000 per annum which is not always clearly understood and is often misinterpreted.

Pertinent statistical tables and charts may be found on pages 17 18 and 19

### NEW VENEREAL DISEASE CASES - EXCL EPTS - NOVEMBER 1950, DECEMBER 1950 AND JANUARY 1951

STATION	Rate per 1000 per year	Rate per 1000 per year	Rate per 1000 per year	Cases per 1000 Troops
	NOVEMBER 50	DECEMBER 50	JANUARY 51	JANUARY 51
Fort Belvoir	22.93	19.92	20.70	1.588
Fort McNair	-	-	-	-
Fort Myer	-	5.59	3.16	.242
US Army Dispensary, Pentagon	-	-	-	-
All Others	7.45	6.51	7.83	.600
Total - Military District of Washington Units	14.76	12.71	13.52	1.037
Army Medical Center - Medical and Holding Detachments	-	-	4.49	.333
Total - Dept/Army Units	13.11	11.29	12.62	.964

**Do You Know That:** the cost to the medical school for a four year course in medicine is approximately \$13,400; and that the tuition paid covers only 25% of this expense?

There are 78 Medical Schools of which 7 are Basic Science Schools.

There are approximately 5100 graduates in medicine per year.

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## PREVENTIVE MEDICINE

CHART 1

ADMISSION RATES BY MONTH, ALL CAUSES, COMMON RESPIRATORY DISEASE AND INJURY  
MDW RATE PER 1000 TROOPS PER YEAR

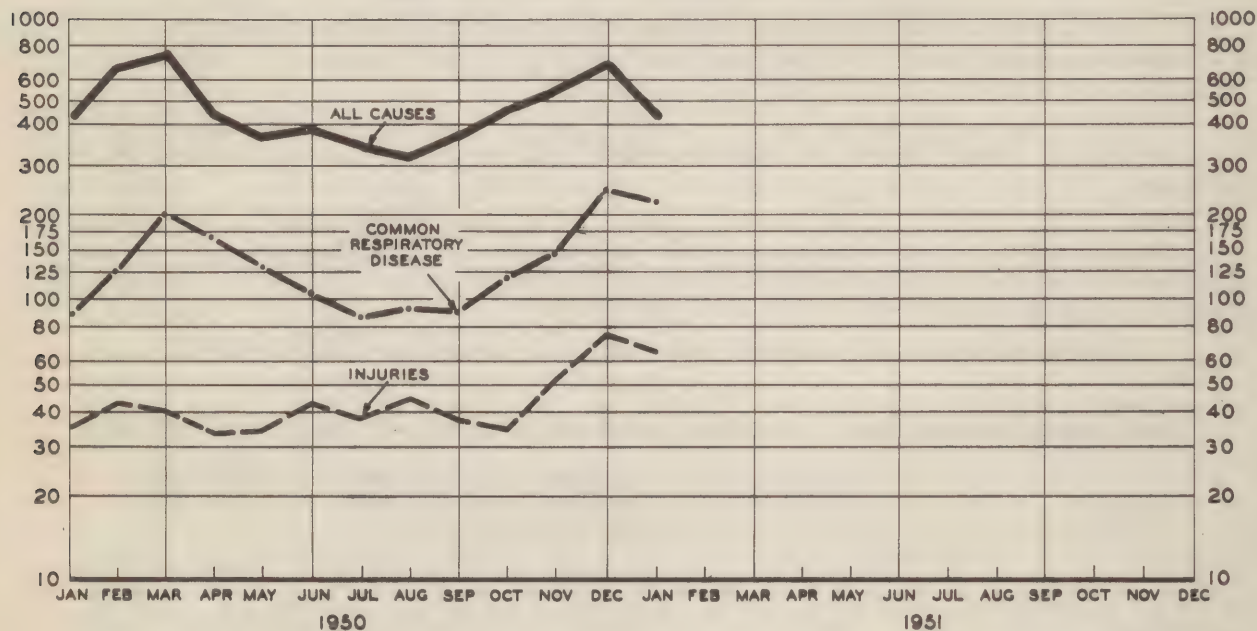
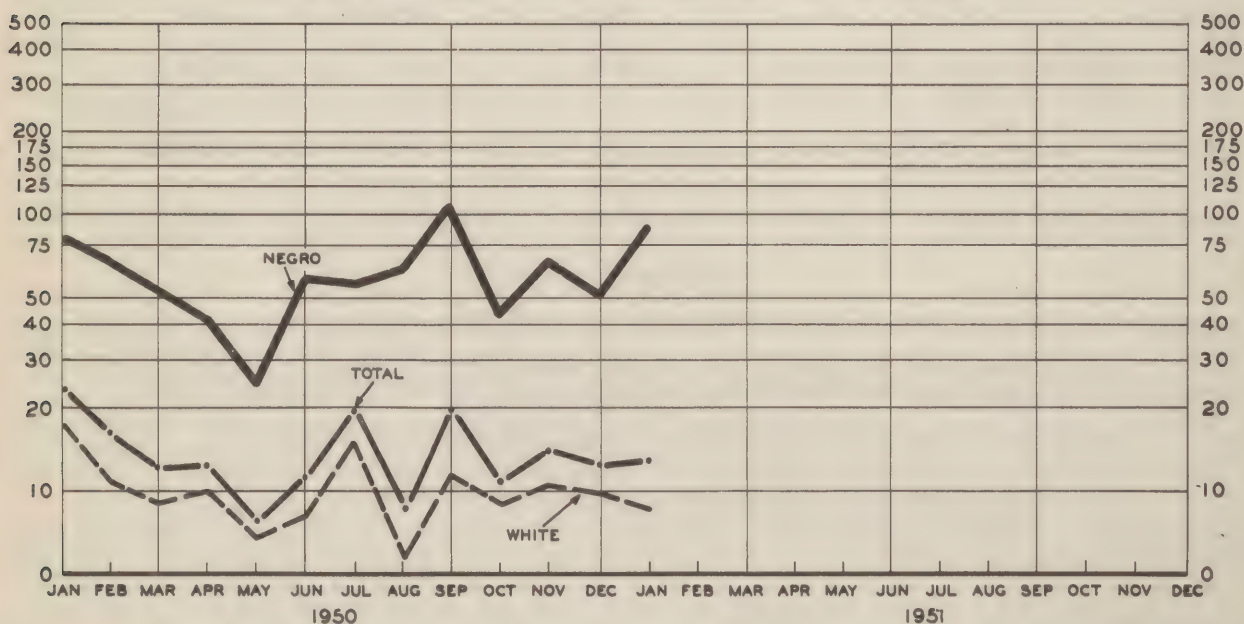


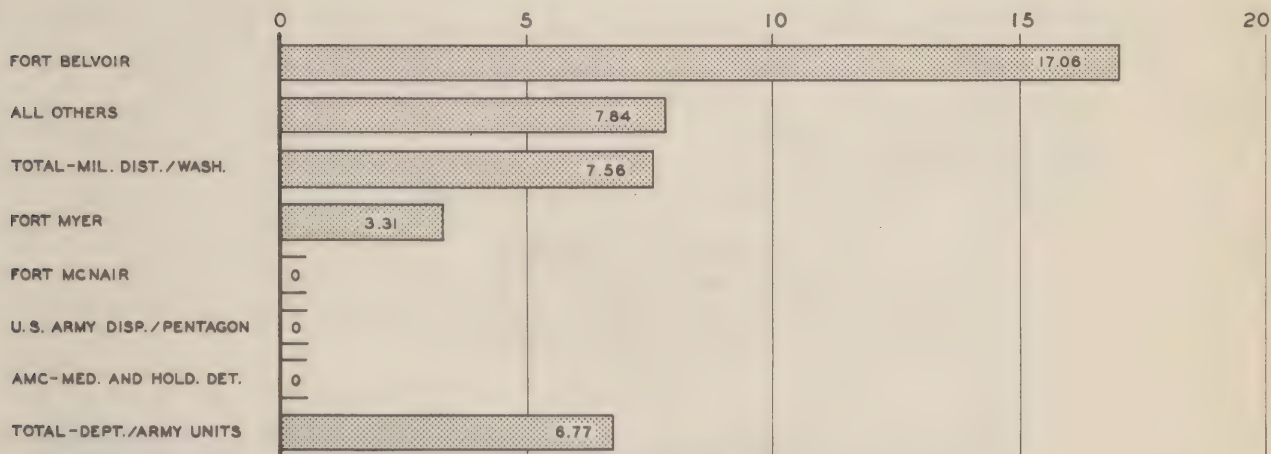
CHART 2

ADMISSION RATES BY MONTH VENEREAL DISEASES MDW NOT INCL. ARMY MEDICAL CENTER  
RATES PER 1000 TROOPS PER YEAR  
INCLUDES ALL CASES REPORTED ON WD AGO 8-122 EXCEPTING THOSE EPTS

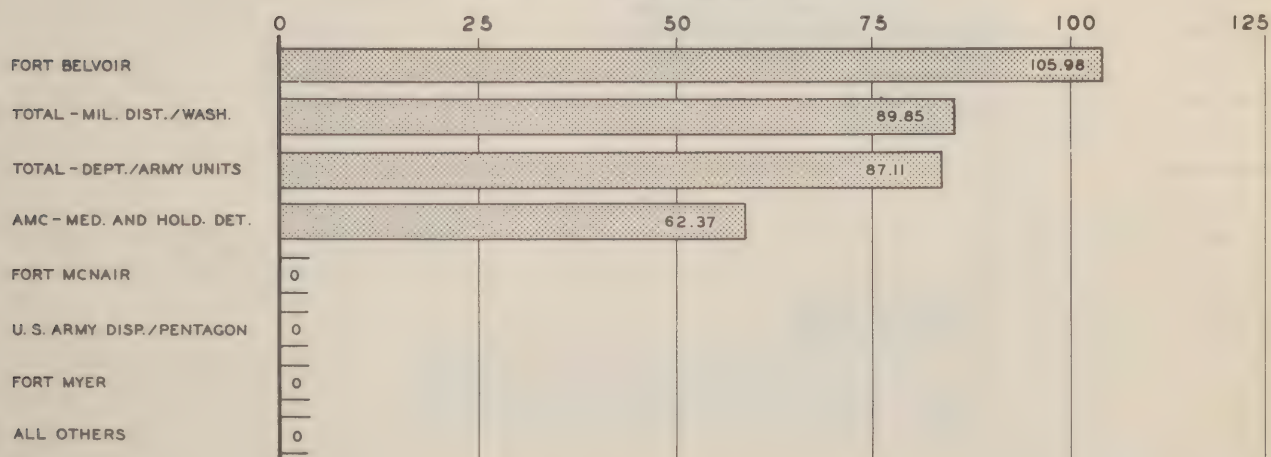


**RESTRICTED**

## VENEREAL DISEASE RATE PER 1000 TROOPS PER YEAR 4 WEEK PERIOD ENDING 26 JAN. 1951 WHITE PERSONNEL (CHARGEABLE CASES)



## VENEREAL DISEASE RATE PER 1000 TROOPS PER YEAR 4 WEEK PERIOD ENDING 26 JAN. 1951 NEGRO PERSONNEL (CHARGEABLE CASES)



## SMALLPOX VACCINATION

Key points of importance in the conduct of successful smallpox vaccination:

- a. Potent vaccine, insured by--
  - (1) Shipment and storage under proper conditions.
  - (2) Use of vaccine within its expiration date.
- b. Satisfactory vaccination, accomplished by--
  - (1) Proper preparation of the vaccination area.
  - (2) The multiple pressure method of vaccination, correctly executed.
- c. Proper interpretation of the vaccination result.
- d. Recording and certification of the vaccination reaction.
- e. Repetition of all unsuccessful vaccinations.

(The above article is from MED. SEC. GHQ. FSC. Surgeon's Circular Letter, Vol V, No. 12, 1 Dec 1950)

**RESTRICTED**

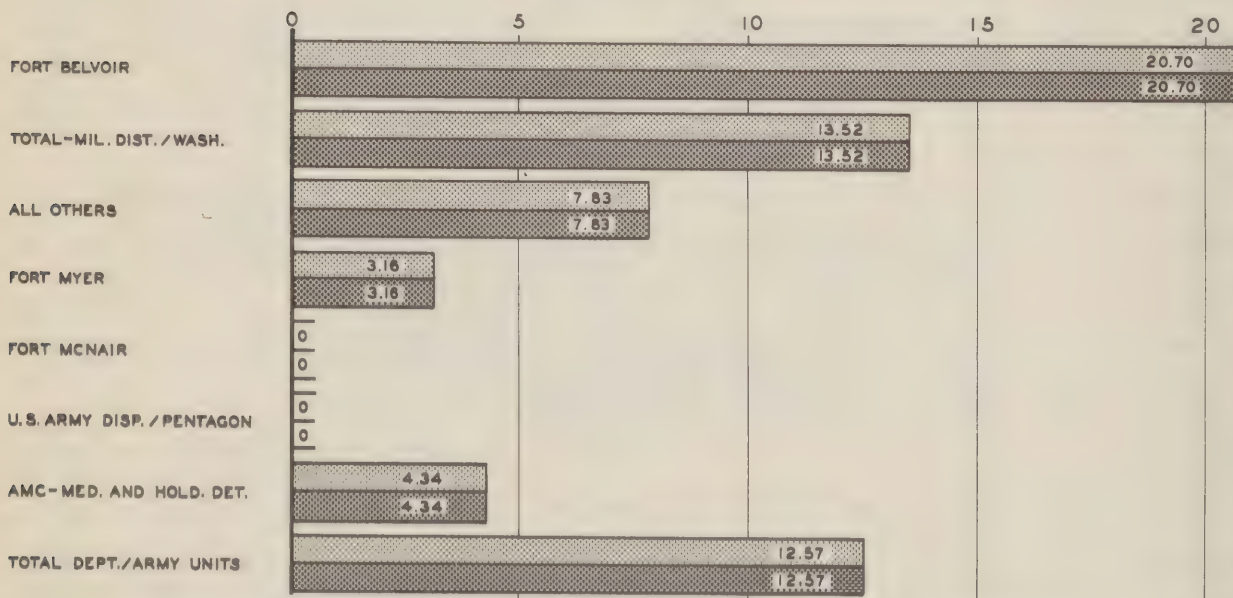
## PREVENTIVE MEDICINE

### VENEREAL DISEASE RATES FOR US\*

(All Army Troops)	NOVEMBER 1950	DECEMBER 1950	JANUARY 1951
First Army Area	14	15	19
Second Army Area	17	20	28
Military District of Washington	13	11	13
Third Army Area	24	21	36
Fourth Army Area	22	25	30
Fifth Army Area	13	8	14
Sixth Army Area	15	17	22
TOTAL United States	17	18	25

\*Compiled in the Office of the Surgeon General and Includes US Army Hospitals

### VENEREAL DISEASE RATES PER 1000 PER YEAR FOUR WEEK & CUMULATIVE TOTALS ENDING 26 JAN. 1951 TOTAL WHITE & NEGRO PERSONNEL (CHARGEABLE CASES)



"Resisting aggression in Korea is not an isolated and unrelated action. It is the culmination of a series of actions which brings to the side of free men the tremendous force of accumulated decision. . . .

The heroic fighting against tremendous odds has pointed up the great lesson of 1950 -- a lesson we might have drawn from the accumulation of events since 1945: that when and if we mobilize and apply greater military force than the Communists, we win. If we don't, we lose. . . .

This resolution to stand and fight is not a departure from the free world's policy of no aggression, no provocation for aggression, and no preventive war. The resolution to stand and fight simply says: we believe that Communists and free peoples can live in the world without war; but if Communists insist that only one or the other can survive, then we are determined that, with God's help, it shall be the free peoples."

(The above is from an address by General of the Army Omar N. Bradley, September 20, 1950).

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# PREVENTIVE MEDICINE

**RESTRICTED**

CONSOLIDATED MONTHLY VENEREAL DISEASE STATISTICAL REPORT  
For the Four Week Period Ending 26 January 1951  
(Data from WD AGO 8-122)(Chargeable Cases)

STATION	R A C E	Mean Strength	Syphilis	Gonorrhea	Other	Total	Rate per 1000 Troops per Annum	Total Days Lost From Duty (Old & New Cases)
Fort Belvoir	W	14143	2	10	0	12	17.06	4
	N	1599	1	9	3	13	105.98	15
	T	15742	3	19	3	25	20.70	19
Fort McNair	W	732	0	0	0	0	-	0
	N	67	0	0	0	0	-	0
	T	799	0	0	0	0	-	0
Fort Myer	W	3944	0	1	0	1	3.31	0
	N	187	0	0	0	0	-	0
	T	4131	0	1	0	1	3.16	0
US Army Dispensary, The Pentagon	W	3661	0	0	0	0	-	0
	N	31	0	0	0	0	-	0
	T	3692	0	0	0	0	-	0
All Others	W	1662	0	1	0	1	7.84	3
	N	2	0	0	0	0	-	0
	T	1664	0	1	0	1	7.83	3
Total - Military Dis- trict of Washington	W	24142	2	12	0	14	7.56	7
	N	1886	1	9	3	13	89.85	15
	T	26028	3	21	3	27	13.52	22
Army Medical Center - Med. & Hold. Det.	W	2794	0	0	0	0	-	0
	N	209	0	1	0	1	62.37	0
	T	3003	0	1	0	1	4.34	0
Total - Dept/Army Units	W	26936	2	12	0	14	6.77	7
	N	2095	1	10	3	14	87.11	15
	T	29031	3	22	3	28	12.57	22

**RESTRICTED**

**RESTRICTED****DENTAL SERVICE**

DENTAL SERVICE -- FOUR WEEK PERIOD ENDING 26 JANUARY 1951

STATION	Military		Civilian		Sit- tings	Amal- gam	Oxy and Amal	Sili- cate	In- lays	Brid- ges	Bridge Repair	Crowns	Dentures			Ex- trac- tions	Calcu- lus Removed	X- Rays	Exam- ina- tions
	Men	Duty Days	Men	Duty Days									Full	Par- tial	Re- pair				
Fort Belvoir	10	325	1	21	3700	458	695	195	3	3	13	7	20	22	20	976	209	1103	1433
Fort McNair	2	52	0	0	273	84	75	19	1	0	1	0	3	6	5	41	24	149	71
Fort Myer, Va.	4	124	1	21	1633	577	121	101	0	3	4	5	7	13	12	142	25	1045	301
US Army, Dispen- sary, Pentagon	6	172	0	0	2653	419	169	112	2	3	10	9	9	17	28	104	266	918	699
All Others	2	61	0	0	483	209	89	42	1	0	1	0	1	9	2	80	37	130	306
Total - MDW	24	734	2	42	8,442	1,747	1,149	469	7	9	29	21	40	67	67	1,343	561	3,345	2,810

**VETERINARY SERVICE**POUNDS MEAT AND MEAT FOOD AND DAIRY PRODUCTS INSPECTED JANUARY 1951  
(Data obtained from WD AGO Forms 8-134)

STATION	CLASS *	CLASS *	CLASS *	CLASS *	CLASS *	CLASS *	CLASS *	TOTAL
	3	4	5	6	7	8	9	
Fort Lesley J. McNair		82,174	139,649	4,517	224,005		76,065	526,410
Fort Belvoir, Virginia		751,831	234,575		1,115,092	125,241	529,631	2,756,370
Alexandria Field Buying Office		590,013	103,127		711,775		64,452	1,469,367
Fort Myer, Virginia		228,021	193,480		393,743	9,819	153,746	978,809
Cameron Station, Virginia		205,085	183,873		355,885	5,223	133,077	883,143
MDW Veterinary Detachment	456,015							456,015
Army Medical Center		244,822	150,409		395,006	12,277		802,514
The Pentagon						345,669		345,669
TOTALS	456,015	2,101,946	1,005,113	4,517	3,195,506	498,229	956,971	8,218,297

**REJECTIONS:**

Insanitary or Unsound								
Alex. Field Buying Office		20,359					60	20,419
MDW Veterinary Detachment	2,283							2,283
Army Medical Center					225			225
Not type, class or grade								
Alex. Field Buying Office		7,924						7,924
MDW Veterinary Detachment	5,494							5,494
TOTALS:	7,777	28,283			225		60	36,345

\*Class 3 - Prior to Purchase

\*Class 4 - On delivery at Purchase

\*Class 5 - Army Receipt except Purchase

\*Class 6 - Prior to Shipment

\*Class 7 - At Issue

\*Class 8 - Purchase by Post Exchange, Clubs,  
Messes or Post Restaurants

\*Class 9 - Storage

**OUTPATIENT SERVICE****OUTPATIENT SERVICE**

Consolidated statistical data on outpatient service, Military District of Washington, less Walter Reed Army Hospital, are indicated below for the four - week period ending 26 January 1951:

**ARMY:**

Number of Outpatients . . . . . 6513

Number of Treatments . . . . . 22245

NUMBER OF COMPLETE PHYSICAL EXAMINATIONS CONDUCTED . . . . . 1394

NUMBER OF VACCINATIONS AND IMMUNIZATIONS ADMINISTERED . . . . . 4948

**NON-ARMY:**

Number of Outpatients . . . . . 8623

Number of Treatments . . . . . 21950

**HOSPITAL MESS ADMINISTRATION****HOSPITAL MESS ADMINISTRATION**

STATION	OCTOBER 1950	NOVEMBER 1950	DECEMBER 1950	JANUARY 1951
Fort Belvoir				
Income per Ration	\$1.1625	\$1.1432	\$1.18	\$1.18
Expense per Ration	.9538	.9105	1.08	1.02
Gain or Loss	+.2087	+.2327	+.10	+.16

**RESTRICTED**

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# CIVILIAN EMPLOYEES HEALTH SERVICE PROGRAM

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## PROGRESS REPORT, DEPARTMENT OF DEFENSE, CIVILIAN EMPLOYEES HEALTH SERVICE PROGRAM

The Department of Defense, Civilian Employees Health Service Program was established as of 1 July 1950, at the seat of government, as directed by letter from the Secretary of Defense, dated 7 April 1950. The Department of the Army was designated to provide a civilian health service program consolidating for this purpose the Departmental Nursing Service of the Navy, the Civilian Medical Division, Office of the Secretary of the Army, and the Army Federal Employees Health Service, Military District of Washington. Supplemental directive necessary to effect the program was prepared and submitted to the Office of the Secretary of Defense where it was approved and issued by the Department of the Army.

The Civilian Employees Health Service Program, Department of Defense, operates generally in accordance with SR 40-220-5 under the technical and professional control of the Surgeon General, Department of the Army. The administration, operation and the supervision is the responsibility of the Commanding General, Military District of Washington.

The progress noted in the operation of the Civilian Employees Health Service Program is as follows:

### 1. Personnel

Consolidation of all personnel of all unit and branch dispensaries is effected. All personnel are qualified Civil Service personnel, medical, nursing, technical and clerical. All dispensaries and branch units have a civilian physician assigned for duty.

### 2. Property and Supply

The Civilian Employees Health Service is satellited on Fort Myer, Virginia, for all logistical support. All medical property has been consolidated and shipped to the appropriate technical service supply officer. The quartermaster and signal property has been inventoried and is in the process of being shipped to appropriate technical service supply officers. Laundry service has been established and is furnished by the Quartermaster Laundry, Fort Myer, Virginia.

### 3. Reports

Medical activities are reported by each dispensary and branch unit to the Office of the Medical Director, where they are consolidated and forwarded.

### 4. Medical Services

a. Small scattered groups of Department of Defense employees, ranging in number from 5 to 300 were found in the Metropolitan Area of Washington. Medical service for these individuals is arranged, satelliting them on the nearest Department of Defense, Civilian Employees Health Service dispensary or branch unit. On 1 July 1950, the number of Department of Defense personnel, authorized to receive medical services under the program was reported as 42,977. The expansion which has taken place in the Department of Defense brings the number of civilian employees eligible for medical services at the Civilian Employees Health Service dispensaries up to 60,946.

b. Physical examinations: Standard procedures have been developed for the performance of physical examinations so that the procedures are uniform throughout the program. All physical examinations at the present time are considered to be current.

c. Emergency on-the-job treatments: Procedures are in the process of draft to develop uniform emergency medical, surgical and dental treatment for all dispensaries and branch units.

### 5. Environmental Health

A schedule of sanitation inspection and industrial survey is being developed for all buildings where a Department of Defense, Civilian Employees Health Service Dispensary is located. The technical facilities of the Army Environmental Health Laboratory, Edgewood, Maryland, are utilized in the implementation of this phase of the program.

### 6. The American Red Cross Blood Donor Program

The Civilian Employees Health Service Program cooperates with and assists the American Red Cross in the conduction of the Blood Donor Program each Friday at room 3A-750, The Pentagon.

# CIVILIAN EMPLOYEES HEALTH SERVICE PROGRAM

Space, the services of a qualified nurse and such clerical help as necessary is furnished.

Liaison is established with the Office of Interdepartmental Administrative Services, Office of the Secretary of Defense. This contact furnished information regarding locations of building space allocations for the Metropolitan Area of Washington whereby medical service is provided for Department of Defense employees occupying these buildings.

Floor plans and space requirements have been submitted to the Office of the Chief, Management Division, Office of the Secretary of the Army, for the establishment of a Department of Defense, Civilian Employees Health Service dispensary at Tempo Building U and the expansion of the dispensaries located at Main Navy Building and Building Tempo 7.

ARMY FEDERAL CIVILIAN EMPLOYEES' HEALTH SERVICE REPORT				REPORTS CONTROL SYMBOL MED-30 (R1)					
(See Reverse Side for Instructions)				For period of 1 July thru 31 December 1950					
TO: Department of the Army Office of the Surgeon General Washington 25, D. C.		1. NAME AND ADDRESS OF INSTALLATION MAKING REPORT Office of the Medical Director Civilian Employees Health Service Room 2D201, The Pentagon							
2. AVERAGE DAILY STRENGTH OF CIVILIAN PERSONNEL EMPLOYED DURING QUARTER		3. MAJOR HAZARDS (During Report Period)							
MALE 55%									
FEMALE 45%									
TOTAL 60,946									
4. PERSONNEL ADMINISTERING PROGRAM		FULL TIME		PART TIME		SHIFTS			
a. MEDICAL OFFICERS OR PHYSICIANS		5		4		1 shift 40 hours			
b. NURSES		33							
c. TECHNICIANS, CLERKS, ETC.		16		1					
TOTAL PERSONNEL		54		5					
5. UNIT EQUIPMENT AT END OF QUARTER		NUMBER OF UNITS		NUMBER OF BEDS					
a. INDUSTRIAL DISPENSARIES		9		53					
b. INDUSTRIAL DISPENSARY AID STATIONS		7		32					
c. <del>STAFF CAR</del> Staff Car		1							
6. OCCUPATIONAL AND NONOCCUPATIONAL ILLNESS AND INJURY DATA FOR QUARTER BY MONTH									
TYPE	NUMBER OF CASES			NUMBER OF TREATMENTS			NUMBER OF HOURS LOST		
	1ST MONTH	2D MONTH	3D MONTH	1ST MONTH	2D MONTH	3D MONTH	1ST MONTH	2D MONTH	3D MONTH
a. OCCUPATIONAL									
1. ILLNESS	3	11	8	10	29	20			
2. INJURY	990	1,125	974	1,610	1,713	1,470			
b. NONOCCUPATIONAL ILLNESS AND INJURY	22,572	23,670	24,151	27,858	29,585	30,002			
7. PREVENTIVE MEDICAL ACTIVITIES (Number)									
a. PREPLACEMENT EXAMINATIONS		8,772		e. SEROLOGICAL TESTS		70			
b. PERIODIC EXAMINATIONS		142		f. X-RAYS OF CHEST		16,313			
c. HANDICAPS CLASSIFIED		941		g. CONSULTATIONS		4,308			
d. REJECTIONS		0		h. IMMUNIZATIONS		108			
Rx		7,224							
Rest Ordered		4,891							
Referrals		3,737							
Injury Follow-up		4,437							
X-rays initiated		3,516							
DATE		SIGNATURE OF MEDICAL OFFICER, CONTRACT SURGEON OR PHYSICIAN IN CHARGE							

DA AGO FORM 8-177 REPLACES WD AGO FORM 8-177, 1 MAR 1948  
1 MAY 49 WHICH IS OBSOLETE

16-59760-1

## COMMUNICABLE DISEASES

While we cannot see the germs that make us sick we know they're everywhere, going for a FREE RIDE --

- in the AIR we breathe
- in the FOOD we eat and the WATER we drink
- or in the belly of a mosquito, fly, cootie, flea, chigger or snail.

A few SIMPLE PRECAUTIONS will go a long ways in keeping you in good health.

TO PREVENT THE SPREAD OF DISEASE THROUGH AIR --

### DO THIS

- Cover your nose and mouth with a handkerchief when you cough or sneeze
- Sleep "head to foot" in quarters where bed space is limited
- Change as soon as possible your wet clothing, shoes and socks
- Keep away from places where you know there are sick people
- Use compound or sprinkle floor to keep dust down when sweeping
- Wear clothing suited to weather conditions
- Ventilate rooms by opening windows top and bottom
- If you over-exercise put on additional clothing until you are dry

### A. Air-Borne Diseases

The diseases most commonly carried from one person to another in the air are --

- common cold
- influenza
- tuberculosis
- measles
- pneumonia
- scarlet fever

A GOOD HEALTHY COUGH OR SNEEZE CAN LOAD THE AIR WITH DYNAMITE

### DON'T DO THIS

- DON'T sit or sleep in a draft or under an electric fan
- DON'T drink alcohol to cure a cold
- DON'T take laxatives unless the doctor orders you to
- DON'T allow yourself to become over-tired
- DON'T shake your handkerchief around in the air
- DON'T spit in public places

**RESTRICTED**

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